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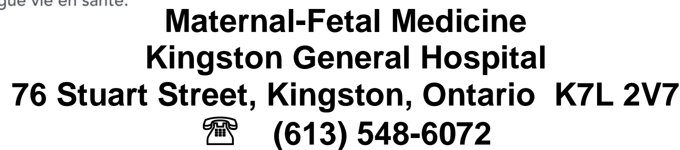

Maternal-Fetal Medicine
Kingston General Hospital
76 Stuart Street, Kingston, Ontario K7L 2V7
☏ (613) 548-6072

Please complete all of the following information and fax to: (613) 548-1330

Referring Physician / Midwife Information

Name: ______________________________ Hospital: ____________________

Phone: (_______)_______________ Fax: (_______)____________________

E-mail:______________________________

Patient Information

Name: ______________________________ Phone: (________)______________

Date of Birth: ____________________ (YYYY - MM - DD) Health Card Number: ____________________

Does patient need translator? ☐ No ☐ Yes Language: ______________________________

Previous referral to another specialty in ***this*** pregnancy? Specify: ______________________________

Reason for Referral: ☐ Consult ☐ Transfer of Care ☐ Non-Pregnant Consultation

Maternal Age: ______ yrs LMP:______________EDC: ________________ Gest. Age ________ wks

For patients in the first trimester:
Date of nuchal translucency ultrasound: ____________________

Maternal Concerns:

Fetal Concerns:

To process this referral, the following documentation is required:

Antenatal Records	Ultrasound Results
All relevant antenatal blood work	Reports from other specialists involved in this patient's care
PAP and cervical/vaginal swabs	
FTS / IPS / MSS Results	Other lab tests pertinent for referral

Reports of abnormal findings in previous pregnancy or child *(e.g. Ultrasound, autopsy, chromosomes)*

Please continue to provide care for your patient until seen by Maternal Fetal Medicine.

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